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patients. However, to further improve the late outcome of extensive endarterectomy and reconstruction of the LAD, a precise analysis of the late mortality and late angiographic findings is necessary.

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IS A "NARROW AORTA–MITRAL ANGLE AND ASSOCIATED FACTORS" ASSOCIATED WITH DEVELOPMENT OF SYSTOLIC ANTERIOR MOTION?

To the Editor:

The report by Manabe and colleagues[1] highlights an important factor that might contribute to the likelihood of the occurrence of systolic anterior motion (SAM), which is an undesired complication to be encountered in mitral valve repair procedures.

Many attempts have been made to understand the underlying mechanisms of SAM, which the authors mentioned in their report.[1] We congratulate the authors for their enthusiasm in revealing the mechanisms underlying SAM, and we believe their contributions have great importance.

We wanted to further contribute to this issue, in line with the statements of the authors. As mentioned by the authors, some of the factors that contribute to the development of SAM have been previously defined. These factors can be grouped into major and minor factors. The major group includes excess valvular tissue and an undersized annuloplasty, and the minor group includes a narrow aortic mitral angle, a hyperkinetic small ventricle, a bulging interventricular septum, and an abnormal configuration of the anterior leaflet.[2] We agree with the authors' statement that a "high ejection fraction and low left ventricular systolic diameter are associated with development of SAM."[1] Moreover, we also believe that in cases with a low left ventricular volume, a similar association can be determined. The aorta–mitral angle must be narrow in all cases with a low left ventricular systolic diameter and low left ventricular systolic or diastolic volume. This also results in overestimation of the measured ejection fraction. A narrow aorta–mitral angle facilitates SAM by positioning the anterior leaflet close to outflow tract and displacing the filling chamber of the left ventricle, which becomes a part of the subaortic region.[2] This condition explains why the measured ejection fraction is greater; that is, why the measured left ventricular end systolic residual volume is less. Therefore, a narrow aorta–mitral angle, low left ventricular systolic diameter, low left ventricular systolic volume, and high ejection fraction can be grouped under the same heading "narrow aorta–mitral angle and associated factors."

We believe that this different viewpoint when exploring the factors related to the development of SAM could help surgeons understand and manage the issue.

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Notice of Correction

Re: De Bonis M, Lapenna E, Lorusso R, Buzzatti N, Gelsomino S, Taramasso M, Vizzardi E, Alfieri O. Very long-term results (up to 17 years) with the double-orifice mitral valve repair combined with ring annuloplasty for degenerative mitral regurgitation. *J Thorac Cardiovasc Surg*. 2012;144:1019-26.

In the above-mentioned article, the spelling of Dr Buzzatti's surname was incorrect. The corrected author list is printed below.

Michele De Bonis, MD, Elisabetta Lapenna, MD, Roberto Lorusso, MD, PhD, Nicola Buzzatti, MD, Sandro Gelsomino, MD, PhD, Maurizio Taramasso, MD, Enrico Vizzardi, MD, and Ottavio Alfieri, MD